THE HABIT CLINIC FOR THE PRE-SCHOOL CHILD

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FROM what has been said by Dr. Richards and Dr. Anderson, one does not need to dwell further on the work of mental hygiene as touching childhood, its history, and recent manifestations in this country. Nor does one need to emphasize more fully to a group such as this the real need for such work. However, granting the need for juvenile mental hygiene advancement, we feel that in a symposium of this nature it is pertinent that we focus our attention for a part of the time on that vastly important period of two to six. Up to quite recently this strategic period has been solely within the scope of the pediatrician and not the psychiatrist. As psychiatrists we feel that the problems of these years are within our territory, and that with a psychological background, as well as a medical one, we can be of real service in this field. We feel that it is not a problem for the psychiatrist alone nor the pediatrician alone, but for both, working together.

Our knowledge of adult psychoneuroses has given us a better understanding of the psychological twists of childhood. There is reason to think that there are conflicts present in childhood which give rise to psychoneuroses similar to those of adults, possibly more simple in their structure. In looking more especially at habits, we do not feel justified in arguing that the presence of an unusual habit in childhood bespeaks an adult psychoneurosis or psychosis, yet we do feel justified in saying that many of these habits are indications of an emotional instability, which, if allowed to develop undirected, may well make for an inefficient adult adaptation. Failure on the part of an adult to adapt himself properly gives us alcoholism, drug addiction, delinquency, prostitution, convulsions, and a variety of other abnormal modes of meeting the tasks at hand. We feel that these reactional make-shifts may often be traced back to an inefficient reaction—a habit in childhood. If these conflicts—these poor adaptations to reality—can be met and coped with at four instead of forty, what a vast amount of discomfort—personal, social, and economic—we have saved the patient, his family, and the state. We are willing to rest our argument with this superficial indication of our position, feeling assured that you are in agreement as to the vital importance of the two to six period. Also I feel sure that in Dr. Catton and Dr. Harvey's consideration of these problems the connection between childhood mal-adaptations and behavior problems of later life will be stressed.

We are bringing to you a report of work accomplished in Oakland and in Berkeley, where we are unusually fortunate in having the necessary equipment and facilities for work, and where at the present time we have a fairly satisfactory child guidance machine—a group of clinics at the Oakland Health Center, at the Oakland Baby Hospital, and at the Berkeley Health Center. Each of these clinics is provided with adequate space, proper surroundings, social service workers, a psychologist, and close contact with an established group of specialists for reference work. We feel that we may be justly proud in being able to present a working organization to the National Mental Hygiene Committee, and I believe the first real effort of this sort in Northern California.

We are modeling our work largely along the lines of the work done in the state of Massachusetts by Douglas Thom, where the name "Habit Clinic," to the best of our knowledge, was employed for the first time. The beginning was made in the city of Boston in a most unpretentious manner about two and one-half years ago. A large part of the work at first was done personally by Dr. Thom, later junior workers were drafted from the Boston Psychopathic Hospital, including a psychiatrist and a psychologist. The work has spread from this rather inconspicuous beginning and is now reaching well into the state. The ground for this work has been especially well broken in Massachusetts by a very complete and carefully executed program of mental hygiene. The first habit clinic in Boston included, as Dr. Thom points out, "a psychiatrist one afternoon a week, a pad of paper and pencil, a chair and table in the nursery, and the necessary equipment for making a complete physical and neurological examination."

Work not dissimilar to this had been done earlier in New Haven with Gessell, and I believe also in New York. But I think that we are correct in saying that the term "Habit Clinic" was employed in the Massachusetts undertaking for the first time.

What is the scope of a habit clinic? The province of such a clinic is to consider and treat improper modes of dealing with childhood problems—that is, within the period of two to six years. Also, we should include within this scope an attempt to aid in the formation of habits which will be of use in developing a well-rounded adult personality. To be specific, what are typical situations to be dealt with in a habit clinic for pre-school children? First, we have faulty adaptation to the feeding situation—vomiting when certain foods are given, rumination, regurgitation. Then we have faulty sleep habits—night terrors, sleep-walking, sleeplessness, bed-wetting. Masturbation is one of the most frequent of our problems. Dirt-eating, thumb-sucking, lying, cruelty, speech defects, day-dreaming, tics, undue affection for a member of family mannerisms, are but to mention a few of our situations.

To be more specific, I can summarize a few cases recently encountered.

Case I—Boy, aged 5. Complaint: Bed-wetting, running away from home, facial and nasal tic. As to the bed-wetting, we find that he is given water and tea in abundance at a late supper, is not sent to the toilet before retiring, and is scolded continually about this shortcoming. We try to cut out the scolding and to change the dietary and sleeping situation. As to the running away, we find that the child has an excessive fear of the father, induced by too frequent punishment, often considerably delayed after the offense. Due to this delay, the child has stored up a fear and a resentment for the father, and gets away from home when the father is about. The facial and nasal tics are on a physical basis in part. The child has large tonsils—a mild rhinitis is induced, the infection ascending to the eyes where a mild blepharitis is caused, the constant irritation in the nose causing the snuffing, and in the eyes the blinking. A removal of the tonsils has largely remedied this condition. Imitation also

plays a part here, for we find that the patient's older brother had a similar habit.

Case II—Boy, aged 5. Complaint: That he soils himself in kindergarten. In this case we find physically an underdeveloped child, with poor muscular tone. As a baby, and even later, we find that the mother worked out and the boy was left to the tender ministrations of an older sister. Very little attention was given to the bowel movements, and the child was not taught to go to stool at regular intervals. Our present trouble is largely a continuation of this untidy habit developed during babyhood.

Case III—Boy, aged 6. Complaint: Masturbation. Here we find a rather long foreskin with difficult retraction and evidence of irritation. Our first step is circumcision. We changed from a nightgown to sleeping-suits, and arranged for the child to sleep alone. We have also arranged that the child is not to be put to bed until there is evidence that he is sleepy; heretofore, the youngster going to bed immediately after dinner, before he was sleepy and lying there fully an hour before he went to sleep—a golden time to foster the habit we are trying to overcome.

Case IV—Girl, aged 5. Complaint: Stammering. The child had been somewhat slow in learning to talk. This was a source of annoyance to the parents, and they constantly urged her to talk, scolding her at times for being slower than their other children. Some well-meaning teacher told the mother to make the child repeat sentences as fast as possible. This was tried and the child's defect became much more pronounced. In our clinic treatment, we changed the type of therapy to include deliberate pronunciation and breathing exercises, and tried to establish the necessary rapport between the child and the examiner.

These cases I have summarized, not because there is anything very spectacular or remarkable about them, but rather to show you the type of thing we encounter in our habit clinic work, and to emphasize the types of disorder which we feel are worth remedying. We feel that therapy along these lines can make the difference between a normal adult and an adult defective in some emotional respect, possibly a dependent on state or county.

ORGANIZATION AND TECHNIQUE OF A HABIT CLINIC

In the first place, to my mind, the setting of such a clinic should be given most careful consideration. I feel very strongly that it should be located in an established clinic or nursery. For the proper handling of a clinic one needs the constant proximity of specialists in other lines, the internist, the surgeon, the oculist, and so on. A dentist also is an essential part of the general clinic personnel. The actual clinic surroundings should be carefully considered, so that as far as possible the child is freed from the usual terror of white-walled hospitals and outpatient departments. Ordinary nursery accessories should be in abundance—sand pile, toys, books, games, and, if possible, a competent director for these activities. While I feel that to a certain extent it is valuable to keep before the child the fact that he is coming to the physician for a purpose, yet we do want him to come in to us from as near a normal environment as we can provide. Toys in the examining room are useful at times. Small chairs and a small table are worth getting. Needless to say, examination paraphernalia should be inconspicuous.

We find it more satisfactory to discuss the situation with the parent before seeing the child (leaving the child with a nursery attendant). Then to have the child in with the parent, adhering largely to commonplaces rather than going directly to the situation in question, or giving the mother an opportunity of covering the situation before the child, emphasizing, as she all too frequently tries to do, the fact that her child is a "nervous child," how he annoys the family, how many other members of the family have suffered from nervous complaints and such-like data, which, of course, tends to make the situation worse as far as our patient is concerned. Then, after a degree of rapport has been established, we like to see the child alone for a few minutes; this is not always accomplished until the second visit. These visits alone with the child, we feel, are of real value and often give us the clue to the situation. These sessions are of real therapeutic value, and it is a satisfaction to find that your small patients come to look forward to their clinic visits, and pride in the week's attainments prove of no small value in habit correction.

There is, of course, no deep mysticism or any subtle psychiatric procedure employed, but only an attempt made to dispense common sense in small doses. Usually, the mother must be very carefully instructed in the things to do, and more important, in the things not to do. And, most important, the social service worker or the visiting nurse should make repeated home visits to see that such instructions are followed. In many of our cases the cleaning up of the home situation automatically clears up the habit situation.

After dealing with the parent, the situation is gone over in as simple a way as possible with the youthful patient, pointing out frequently that the reaction complained of is immature, and not worthy of him. We try to dispel the all too frequent belief of the child that his habit is something of dire moment and consequence. We explain to him that, although it is not entirely admirable, yet it is not of the greatest importance and that we fully expect that it will disappear. Sometimes we outline simple lines of therapy for the child, breathing exercises, co-ordinating muscle movements, simple dance movements. Then, most important, we outline a program of positive attainments and aim at the establishment of a useful set of habits. A program of helpfulness in small duties about the home, conduct in kindergarten and in the playground is covered.

In outlining these positive situations, we are keeping in mind several salient points of child psychology, which we feel are worth mentioning in passing. These are: (1) Reasoning power of the child; (2) ability to imitate; (3) ability to accept and act on suggestion; and (4) the need of approval.

The power of reasoning in young children, especially in infants, has been a source of discussion for years, and we only want to point out that beyond doubt we give a young child credit for all too little intelligence. His mental processes are far ahead of his powers of speech, as anyone can verify who has had opportunity of watching children. In the practical management of children we find that an appeal to reason is often useful before a child can express himself. For this reason, it is poor policy to feel that we can fool a child with any silly explanation that comes to mind. It is much safer to err on the side of crediting him with too much intelligence rather than with too little.

As to our second point—the ability to imitate. This ability can be used as a real aid in building up a set of good habits and shaping a satisfactory character. A cheerful, bright, alert, interested mother will, in most cases find the same sort of child, whereas a surly, scolding, nagging mother cannot complain of a nervous child. If the family clothes are thrown hit or miss about the room on retiring, one cannot be surprised if Johnnie's clothes are likewise distributed. If the sleeping and eating habits of the family are slovenly, one must look for similar habits in the small boy of the family.

Our third attribute—the ability to accept and act on suggestion—is possibly our greatest asset in dealing with the problems of the nervous child. With ordinary suggestion, tactfully applied, we can induce habits of orderliness and precision in a child without any great deal of difficulty. It cannot be done immediately, but every success makes the next attempt less difficult. Suggestion is a real factor, if well used, but without common sense is useless. By this we mean, that, if a child of four is busily engaged in pulling the cat's tail, a mere soft-voiced suggestion that he stop this fascinating sport and come to dinner will not suffice, and, if anything, makes the situation worse. If, on the other hand, when his attention can be gotten, it is suggested to him that some other pursuit—eating his meal—is just what he most wants, his attention is taken from the cat, not focused upon it as it was in the first place, and the beginning made for a new and beneficial association. As has been pointed out in the case of army orders, the men are brought to attention before the order is given, not issuing it while their attention is on some other move.

Our fourth and last outstanding point is that very prominent desire for approval that every normal child manifests. Approbation and desire to hold the center of the stage play no small role in juvenile psychology and must be taken into account. Every child craves a certain amount of credit for work well done, and a well-rounded character will not result if this is not obtained. Too free an approbation is bad, but just praise well-applied helps more than the hair-brush. No child should be given a free lease on the center of the stage, but focusing family attention on the child, in moderation, is helpful. A too frequent repetition of the adage, "Children should be seen and not heard," is the cause of no few nervous disorders, and is conducive of a seclusive, shut-in make-up, which forms a breeding place for subsequent difficulties of adaptation.

We feel that the physical consideration should be large in habit cases. To be concrete, we feel that circumcision should be advocated at the least sign that it is needed. In normal children, we may frequently disregard this necessity, but with the nervous child, even a slight source of irritation may be enough to swing the pendulum in the wrong direction; consequently, circumcision may be neurologically indicated when it is not surgically so necessary. Tonsils and adenoids must go, with an accompanying removal of a variety of facial tics. Eyes should have early attention if there is any indication of muscle trouble. The orthopedist must frequently be consulted as to posture and deformity. Focal infections should not be forgotten, although we do not feel justified in cottonizing many of our diminutive patients. Nutrition, too, is to be seriously considered.

A psychologist is an essential part of our clinic. For routine—Binet's—we care not a whit, but for intelligence tests, applied by a good medical psychologist, with an ability to interpret, results in light of special abilities and disabilities we have every respect and look to as a valuable adjunct of our clinic.

Frequent conferences should be arranged to include the psychiatrist, the psychologist, and the social service worker. This point cannot be overemphasized, for, without the fullest co-operation and understanding between these three viewpoints, we cannot hope for the fullest accomplishment of our aims.

In closing, then, if we may sum up the points considered. We have looked briefly at the development of the habit clinic idea in this country, with especial reference to the work in Massachusetts. Our next consideration was a general survey of a habit clinic, with resumés of typical cases. Our final division was a view of the actual mechanics of running a clinic, and our mode of procedure. I should like to close this paper with the words of former Chief C. Macfie Campbell:

"For the nervous child two conditions are eminently salutary: First, a wholesome objective regime, and second an atmosphere of frankness, in which he can get a fair chance to discuss his troubles."

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A Method of Demonstrating Tubercle Bacilli in the Urine—In the method described by Stephen G. Jones, Boston (Journal A. M. A., December 13, 1924), a catheterized specimen of urine is centrifugated at lowest speed for two or three minutes, thereby removing the bulk of the pus and detritus. The supernatant cloudy fluid, containing a few pus cells and the bacilli, is poured off, one-half is discarded and the remaining half is poured into a second centrifuge tube. To this half-filled tube, one-quarter volume of 95 per cent alcohol is added, the remaining quarter being distilled water. This mixture is centrifugated at highest speed for forty-five minutes until clear, the supernatant fluid discarded, and a smear made from the sediment obtained with a flamed wire loop. The smear is allowed to dry and is then fixed by being passed rapidly two or three times through a Bunsen flame. The centrifuge must be an electrically driven high speed machine. When carrying a load of four tubes, it should make from 2000 to 2100 revolutions per minute, which produces a force 1077 times that of gravity. The Ziehl-Neelson stain is employed. A more delicate stain is obtained if a steam bath is used rather than heating the smear with the direct flame. This is easily accomplished by placing the glass slide over the open top of a can containing steaming water. In this way the stain is heated sufficiently without danger of precipitating the dye. Twenty minutes suffices. The preparation is decolorized by exposure to 30 per cent nitric acid, followed by alcohol (Czaplewski's solution) or to 20 per cent sulphuric acid. The pitfalls are that occasionally nitric acid and alcohol may not decolorize all acid-fast bacilli other than tubercle bacilli. Twenty per cent sulphuric acid will decolorize all other acid-fast bacilli, but may also decolorize tubercle bacilli. The decolorized smear is washed with water, and counterstained with methylene blue. Several hours' search will often disclose the solitary group of bacilli which otherwise will be missed.

Adam and Eve were perfectly happy and sweetly contented in the garden of Eden until Satan's prescription was taken and they beheld their naked condition and Eve began making garments of fig leaves and both of them were ashamed of themselves.—Austin Flint (Iowa Medical Journal).